Reproductive Health

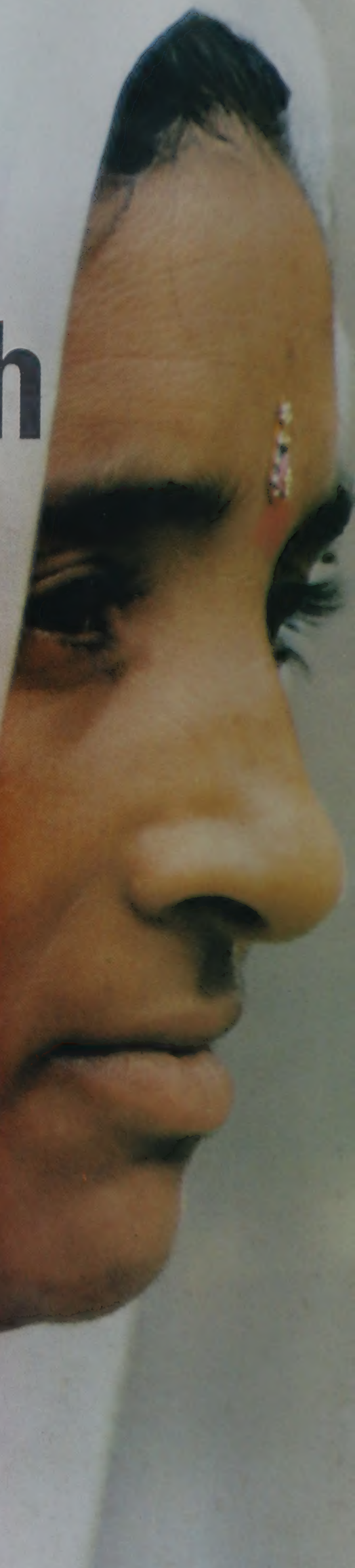
Maternal Health

Abortion

AIDS and HIV

Reproductive Tract Infections

Contraception



CHETNA Woman's Health and Development Resource Centre Chaitanyaa

Thematic Meeting on Reproductive Health
The Need for Comprehensive Policy and Programme
May 4-5, 1994

Organised by
CHETNA Ahmedabad

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CHETNA Woman's Health and Development Resource Centre Chaitanyaa

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INTRODUCTION

A two day meeting on Reproductive Health: Need for comprehensive policy and programme was organised by CHETNA, Ahmedabad, during May 4-5, 1994. The purpose of the seminar was to come out with concrete proposals for policy and programmatic action in some of the major areas of concern in reproductive health: reproductive tract infections (including STDs), abortion, HIV/AIDS, maternal mortality and morbidity, and contraception - keeping in view the need for a comprehensive and integrated approach to these interconnected problems.

The present meeting was one of a series of national thematic meetings held in the country as part of the various activities being sponsored to create greater debate and discussion on the population question and on women's reproductive health, on the eve of the International Conference on Population and Development, Cairo, 1994. The recommendations from the meeting, however, were viewed mainly as an input into the process of national policy and programme planning, at a juncture whence a National Population Policy is in the process of being formulated, and discussions are ongoing on the need for a 'reproductive health approach'.

Each of the major areas of concern in reproductive health was introduced by a team of two or three experts and resource persons. They highlighted some of the most important issues related to the medical and social dimensions of each problem, and also presented a critique of existing policies and programmes in the area.

This was followed by discussion in smaller working groups, to deliberate further on issues outlined in plenary presentations and to add to these where necessary; to share experiences and to make concrete recommendations for policy and programmatic action.

Some of the recurrent themes related to policy were:

- Increased allocation for health services as a whole
- Redressal of the overemphasis on family planning for population control to the detriment of other critical health concerns of woman.
- Provision of comprehensive reproductive health care
- Improvement in the quality of health services and considerable strengthening of primary health care
- Recognition and adoption of preventive and curative knowledge offered by traditional medicine
- Increased attention towards better health education and education on sex and sexuality for both men and women, and especially adolescents
- An important role for NGOs, and for the mass media

SUMMARY OF DISCUSSIONS AND RECOMMENDATIONS

Maternal mortality and morbidity

* High rates of maternal mortality and morbidity are linked to existing gender based discrimination and undervaluation of women in our society. Poorly nourished anaemic women with low social status in the society, low self esteem and lack of appropriate knowledge about health, when pregnant, have greater chances of complicated pregnancy and delivery. Examining and addressing the social dimensions of the problem is therefore as important, if not more, than dealing with its medical dimensions. Narrowly focused medical interventions during pregnancy and childbirth will not reduce the incidence of maternal deaths and morbidity.

* A "social audit" of each maternal death that takes places in the community may be undertaken, so that the underlying medical and social causes are better understood, and steps may be taken for preventing these from recurring. However, such investigation should be kept confidential.

* Maternal mortality and morbidity cannot be addressed successfully in isolation from the wide range of women's health needs. When women begin their pregnancy in a state of compromised health, they are far more likely to suffer complications related to pregnancy and delivery.

* Even the narrow range of women's health needs related to maternity have not received due attention, because of policy makers' emphasis on family planning above all else.The clubbing together of maternal health care with family planning, and the undue pressure on health service providers for achievement of family planning targets, has resulted in the neglect of important components of maternal health. Even today, the vast majority of deliveries in the country are not attended by trained personnel, and there is hardly any post partum care available. There is an urgent need to redress this imbalance in priority setting.

* The quality health care is very poor at all levels, and there is gross insensitivity to women's health needs. Part of the problem lies with limited availability of resources, but the limited professional skills of health service personnel plays a major role as well.

* Training for health staff should be undertaken, to improve and update/upgrade medical skills; to impart management skills so that they optimally utilize resources available at the health facility; and most importantly, to develop their social skills: better communication, and the ability to identify people's needs and understand their perceptions, with a view to delivering services with a humane touch. This is especially important for staff providing services at the first level of contact.

* Training of traditional birth attendants needs to be revived and revitalised. Trained traditional birth attendants can be an important health resource in the community, provided the training content and style is considerably improved, and there is regular follow-up training. In addition, her work should receive systematic supervisory and financial support at the field level.

* Maternal mortality and maternal morbidity are problems which have to be tackled through different approaches. It is not sufficient to assume that programmes addressing maternal mortality will also deal with morbidity effectively; there are several instances where the former has been successfully dealt with, while the incidence of the latter is very high.

* One important problem related to the management of maternal morbidity is that women do not identify many of the conditions to be health problems, till they are fairly serious. This acts as a constraint in seeking appropriate health care. There is need for Information, Education and Communication (IEC) activities in this field; these should be sensitive both to the socio-cultural as well as the gender dimensions of various maternal health problems.

* It is a fact that the health facilities at the community level are ill equipped to deal with maternal morbidities, since they do not have either the diagnostic facilities or the drugs to treat them. The situation of having to go to a district hospital for many of the health problems resulting from complications in delivery/post-partum, has to change.

* Analysis of maternal morbidity and mortality at the national level show that most of the maternal deaths and severest form of morbidities (like VVF,- Vesio-Vaginal Fistula, Rupture Uterus etc.) occur in cases from remote rural and city slum areas. In such area there is an impending necessity of more concentrated efforts for implementing Primary Care, nutrition rehabilitation and screening of HRP (High Risk Pregnancy) during pregnancy. Anemia alone is directly responsible for nearly 20-30% of maternal deaths and in the same proportion it influences indirectly. With resurgence of malaria this is showing upward trend particularly in the above mentioned vulnerable population.

* Beneficial traditional practices related to maternal health care, and local remedies for maternal morbidities should be identified and reinforced.

* Non-governmental organisations, especially those working at the grassroots level, can play a vital role in creating awareness in the community for bringing about changes in social aspects which become a barrier to maternal health.

* The press and the media in general can play an important role in highlighting problems related to maternal health, and in drawing the attention of service providers, politicians and policy makers to maternal deaths and severe impairment to health resulting from maternity occurring in the community. This will help in the recognition of maternal health issues both at the community level as well as at the health service delivery and political levels.

* The community itself should also take responsibilities, such as appropriate utilization of health services, co-operation, active participation so as to help the health infrastructure in achieving/providing better services. The community can also contribute by arranging for the transportation of emergency obstetric cases. With the

emergence of the Panchayati Raj and local government structures, there is scope for making the community responsible and accountable for preventing maternal deaths in villages and promoting maternal health.

* One of the important factors influencing material mortality and severe form of morbidities in vulnerable population of remote rural area, is delay in reaching the appropriate centre. Of the many reasons responsible for the delay, the main is poor or no availability of transport. There is necessity to frame a proper policy regarding transportation of emergency maternity cases. The arrangement of transportation should not rest with the community alone. Analysis of cases from remote rural areas reveal that transportation was available with some of the government institutions or offices in rural areas like PHC, office of Block Development Officer, Irrigation etc. but it could not be used for the above purpose because there is no clear or no policy or separate budget for social purposes. Even the transport at PHC was earmarked only for Family Planning work. Therefore solution to the problem lies at national level of framing a policy.

Reproductive Tract Infections

* Reproductive Tract infections are a major health problem for poor women. Yet they often go undiagnosed and untreated. Untreated RTIs lead to further serious problems such as infertility (15-40% of infertility in Asia is due to infection), with accompanying social rejection and emotional distress; and cervical cancer. Addressing the problem of RTIs needs a multi-pronged approach, and requires changes not only with respect to provision of health services, but also at the socio-cultural level.

* At the socio cultural level, the problem of RTIs is intricately linked with the position of women in present society. The problem therefore needs to be addressed from a gender perspective. It has to be borne in mind that women often suffer RTIs owing to their reproductive anatomy; or as a result of being infected by their sexual partners, over whose sexual behaviour (multiple partners) they may have little control. RTIs may be transmitted also because of poor quality of care and neglect of asepsis when gynaecological or obstetric procedures are performed in health facilities. The issue is further complicated because of women's embarrassment to seek health care for gynaecological problems, as well as due to the low priority accorded to prevention and control of RTIs by policy makers and health service providers.

* The prevention and treatment of RTIs is fairly simple and does not require complicated technology. It is possible for health care providers to prevent and treat RTI cases even at the first level of care.

* The following are some measures that can be adopted at the health centre level:

- Providing technically appropriate routine diagnosis and treatment services and referrals for RTIs (especially for high risk, infertile and pregnant women).
- Providing comfortable and supportive counselling services for both the sexes.
- Strengthening efforts to improve obstetric care particularly in remote rural/tribal areas
- Providing safe and timely pregnancy termination services
- Improving considerably the quality care at different levels to avoid transmission of infection during gynaecological and obstetric procedures
- Providing laboratory services for clinical diagnosis of various RTIs even at the PHC level.
- Strengthening the referral system
- Community education on personal hygiene starting from prepuberal group and above for proper care and protection of external part of Reproductive Tract, menstrual hygiene etc.

* Skill-based and task-oriented training given to existing para medical staff could greatly improve access to timely treatment for RTIs. Such training should be conducted regularly at periodic intervals, rather than be one time events; and follow-up repeat training should be an integral feature of the training plans .

* There should be systematic monitoring and evaluation of the programme through participatory methods and active involvement of the community.

* Traditional medicines used with success in the treatment and control of RTIs need to be identified and their use should be promoted at the community level.

* Prevention and control of RTIs requires far more than medical interventions. A broad based programme of education for both men and women regarding the interaction of medical and social concerns of the problem would be necessary.

* Programmatic action at the community level would include

- awareness raising regarding the underlying medical and socio-cultural factors that predispose a person to RTIs
- influence public opinion in favour of simple preventive measures, for example, the use of barrier methods such as condoms and diaphragms.
- initiate sex education programmes for adolescents and adults of both sexes.
- motivate women's support groups to organise and educate women about RTIs and their outcome, and appropriate self-help and medical treatment for its management; and to provide support for women to bring their sexual partners for diagnosis and treatment of RTIs.
- motivate women's support groups to organise women and facilitate their empowerment so that they assume greater control over their own lives, and over their sexuality.
- motivate men's group to talk to men about RTIs and their prevention, with emphasis on the adoption of safe sexual practices.

HIV/AIDS

* The problem of HIV/AIDS in a situation of low health status of the population and the inability of the health care system to deal with the plethora of health problems, is cause for great concern. It is likely to affect women disproportionately since given their vulnerability to STDs, and to sexual violence, they are at considerable risk of being infected by HIV. Complications during delivery requiring blood transfusion also place them at risk of infection. At the same time, they are less likely to seek, or receive, adequate medical attention. Further, as those responsible at home for caring for the sick, the burden of care would fall on them, causing further stress.

* Given the very meagre financial allocation for health (2-3% of total budget), the HIV/AIDS epidemic poses an alarming scenario. There is likelihood that there will be a heavy financial burden on the programme to control the complications of AIDS such as tuberculosis, cancer, and diarrhoea. This would corner a considerable proportion of the limited resources, and ultimately also affect those seeking treatment for other ailments, especially large populations affected by communicable and infectious diseases.

* If HIV assumes epidemic proportions, it is the young, productive and reproductive age groups which will be most affected. This has profound demographic and developmental implications. An example is the rise in the number of orphans and the need for welfare measures to care for them.

* Policy and programmatic measures to date are grossly inadequate. Most of the action is oriented towards prevention through health education. There is a lack of political will to appreciate the need for action on various fronts, and the allocation of greater resources. There are no consistent or systematic campaigns as yet,towards behavioural change in sexual practices. Many health education messages are blatantly gender biased, portraying 'immoral' women (prostitutes) as perpetrators of the disease. Further, the current programme does not cater to special needs of women.

* The following measures were recommended in relation to service delivery and training of health personnel:

- The quality of services provided in health facilities needs to be vastly improved, and adherence to minimal standards of safety during all medical and surgical procedures and screening of blood being transfused should become the norm. Special attention needs to be paid to safety procedures during deliveries and sterilisation.
- Control and prevention of HIV infection cannot be done in isolation from a good STD control programme, which at present has been a neglected area.
- The HIV/AIDS/STDs services should be made available at the first referral level of health services. The necessary drugs/equipment should also be made available.

- For effective prevention of HIV infection, the availability and accessibility of male condoms of good quality needs to be ensured with immediate effect. Use of female condoms should also be promoted, and supplies of the same made widely available.
- There is a need to initiate immediate cost-feasibility studies on control and treatment of secondary infections resulting from HIV/ AIDS infection.
- Strategic planning for control of HIV infection should pay due attention to high risk groups.
- Staff working at the Primary Health Centre and Sub Centre level,such as TBAs, female health workers, male health workers, other PHC Staff including Medical Officers should be oriented and trained to deal with HIV prevention, diagnosis and management. Such training should emphasise on adherence to safety procedures, and include training for counselling and better communication.
- Interpersonal counselling component should also be inbuilt into all medical and paramedical curricula.

* HIV/AIDS is not merely a health issue, and cannot be dealt with only by the Department of Health. Attempts should be made to involve NGOs and other government departments and agencies in social mobilization/ development activities for mass education and influencing behavioural changes.

* The AIDS control programme is currently top down, male dominated/oriented and non-participatory. It needs to be personalized, and should address sexuality concerns.

* The mass education and awareness raising measures need to develop messages keeping in view the needs of special groups, and need to be more sensitive to the socio-psychological aspects of being a potential HIV/AIDS patient. It needs to help rather than preach.

* The mass media/press should be actively involved in spreading information regarding AIDS/HIV and STDs with a positive attitude.

* NGOs should be involved in educational activities because they have a rapport with and access to the community and to high risk groups.

* There is an urgent need to create general awareness about HIV/AIDs and Sexually Transmitted Diseases (STDs) in the community in order to bring about a positive change in safe sexual behaviour.

* In the present context the critical need for sex education especially of adolescents, should be better appreciated. Special campaigns should be designed to educate them on safe sexual practises and behaviour.

* Gender Sensitization of both men and women, needs to be done including programme staff and policy makers especially in the area related to HIV/AIDS. Policies and programmes to improve women's status in society through education and recognising women as equal partners in process of development, should form an integral part of all long-term strategies to deal with this health problem.

* Violence in the form of sexual assault, rape and molestation of women is widely prevalent, posing additional risks for women in terms of HIV infection. Many of these incidents go unreported, due to the position of women in the Indian society. The rape law which promises protection to women should be made more vigilant and stringent.

* Outdated laws/rules need to be examined again in the present societal context and abolished if necessary. For example the Homosexuality Act may be a major obstacle to seeking screening or treatment by gay and lesbian or bisexual persons, and its relevance needs to be reconsidered.

Abortion:

* Although under the provisions of the Medical Termination of Pregnancy Act, safe abortion services are supposed to be available free of cost at government health facilities, in reality abortion services are expensive. It is the poorer women who suffer as a consequence, because they do not get timely services from government institutions nor they can afford to pay fees/charges in a private hospital. Such situations force them to seek illegal abortions, sometimes leading to severe complications and even death.

* Official data on MTP suggest that the incidence of second trimester abortion are on the increase. Abortion induced in second trimester are comparatively associated with more risks as compared to those carried out during the first trimester.

* There is a tendency to treat induced abortion primarily as a method of birth control. Such a trend is not in the interest of women's health.

* When women seek induced abortion they are often forced by medical officers to accept either the IUD (if they have only one child), or sterilization for family planning, as a requirement for availing MTP services.

* Even while we uphold women's right to terminate a pregnancy, one has to acknowledge that the question of selective abortion of female foetuses poses a tricky problem. The undervaluation of women in society which leads to such practices, needs to be exposed.

* Discussions on abortion more often than not, forget to address the problem of spontaneous abortions. These are not adequately reported and not appropriately recorded. There are indications that factors such as environmental pollution, and especially contact with pesticides play a role in increasing their incidence. Due attention needs to be accorded to this problem.

* The following suggestions were made with respect to service delivery:

  - timely abortion services should be made available free of cost to women seeking it from government facilities. The practice of levying charges underhand should be severely dealt with.
  - appropriate counselling and protection of the confidentiality is a must to prevent women, and especially young girls below 18 years of age, from turning to illegal practitioners.
  - a wide range of contraceptive methods should be made known and available to the women, including natural methods, so that women do not have to take recourse to induced abortion, except as a backup for contraceptive failure.
  - while increasing access to abortion services is necessary, the move to provide menstrual regulation (MR) services through female health workers, said to be currently under consideration by policy makers, may not be desirable, as it may be associated with a higher risk of infection if not performed at a well equipped health facility.
  - no one should be compelled against her wish by service providers, to accept birth control as a condition for provision of abortion services.

* Health education in the community is necessary and needs to address issues such as provisions of the MTP Act; places where quality services are available; desirability of having abortions at earlier stages; avoiding second trimester abortions as it is harmful to get it done again and again or and repeatedly.

* Awareness raising programmes for both sexes, to challenge the undervaluation of daughters, and to empower women to better appreciate their self-worth would be critical to deal with the practice of selective abortion of female foetuses.

* Sex education of adolescents, with an emphasis on pregnancy prevention, is important for preventing teenage pregnancies out of marriage, which are risky and which most often end in illegal termination.

* In terms of legislative changes, the suggestions made were as follows:

  - use of chemical pastes for abortion, which cause extreme damage to women's health, need to be identified, and their production and sale banned.
  - the provisions of the MTP Act, though liberal, still retain the control over decision making with the medical profession. This needs changing, and abortion should be made available on demand, in recognition of women's right to decide whether or not to continue with a pregnancy.
  - in the case of girls below 18 years of age, under the present law her parents (guardians) have to give consent for abortion. This may not always be feasible, and there should be provision for providing abortion services even without such consent if we aim at preventing health complications of illegal abortions.

Contraception:

* Women's (and men's) need for contraception is but a small part of their reproductive health needs, and an even smaller part of their needs for health and wellbeing in general. Undue focus on contraceptive services with a view to control population growth rates has worked to the detriment of women's wellbeing. One has to start with satisfying basic needs such as drinking water and sanitation, and better living. Community health should regain importance. Women's health needs should be looked at holistically, and their reproductive health needs should find appropriate place within this concern for their overall wellbeing.

* The present family planning programme needs to be reviewed and redesigned so that the policies, programmes, administrative procedures and evaluation criteria are more people-centred. In a nut shell, a change in the thinking of the policy planners and programmers is to be ensured. Mere cosmetic changes without the needed honesty and courage to deal with the real areas of human concerns can never sustain the programme.

* The present family planning programme is target oriented, and driven by the need to fulfil specific quotas of acceptors. Service providers at the Primary health centre, sub- centre level and village level are paying more attention to fulfill the targets at the cost of delivery of total primary health care. As a result, other health programmes have suffered inadequate funding and personnel resources, and comprehensive primary health care exists but in name.

* Targets in family planning have destroyed a holistic view even where provision of contraceptive services is concerned. The concern for achieving demographic goals has led to the promotion of permanent methods, in particular, of female sterilization to the extent that 'family planning' has come to be synonymous with sterilization.

* Ever since the backlash following the coercive vasectomy drive of the mid-seventies, the family planning programme has sought to target women alone, and have paid scant attention to contraceptive services for men.

* At present money incentives are given both to the acceptors of family planning method(especially sterilization) and to the service providers, with a view to achieving targets. At times the government even increases these incentives with a view to achieving targets set. This violates the principle of voluntary and free choice especially for the poorer sections of society.

* The target-incentive-disincentive approach has worked more to the detriment of women's interests, since it has led to the provision of poor quality services which are insensitive to clients' needs, and are focused at reducing birth rates even at the cost of women's health. One example of this is the introduction of new contraceptives such as NORPLANT which cannot be delivered safely given the poor quality of health and family planning services, and the lack of even basic infra-structural facilities in several parts of the country.

* One of the basic requirements for contraceptive services to become an enabling and empowering tool for women is education about their bodies and sexuality. There is also an urgent need for widespread coverage of sex education for men, and for adolescents (both boys and girls). Such education should be broad based, and should be accompanied by information regarding family planning methods (including natural) and MTP act.

* The following recommendations were made in the area of service delivery :

- The exclusive focus on family planning to effect fertility decline should be replaced by comprehensive primary health, care including sound reproductive health care, which includes prevention and treatment referral of various obstetric and gynaecological morbidities, and provision of abortion, contraception and infertility services.
- Competent and quality care should be provided for those seeking contraceptive services, and follow-up should be assured.
- Both women and men (couple) should have access to all type of contraceptive information in order that they can select a method of their choice. There should be no compulsion to opt for any one method over the other. Spacing methods, should be made available irrespective of the number of children a woman has, and information should also be given on natural methods of birth control.
- It is time that men are made to take responsibility for the consequences of their sexuality. Male methods of birth control need to be promoted vigorously.

- Counsellors need to be available to give information and guidance regarding choice and acceptance of a contraceptive method. Doctors could themselves play this role, with appropriate training.
- Prior to acceptance of any method, clients should be screened medically for any contraindications. Oral use of checklists and questioning clients to rule out contraindications, is not sufficient.
- Improvement in the quality of services implies staff training (services providers) on an ongoing basis for development and upgrading skills and knowledge. Regular refresher courses should be organised.
- Ensuring adequate/timely supply of material and equipment is another important area needing better attention.
- To ensure that clients get adequate and appropriate services in case of any problem with contraceptive use, each of them should be given a contraceptive card with a record of reproductive and contraceptive history, and the presence of any health problems.
- Guidelines for ensuring minimal standards regarding information to be given, procedures to be adopted, and follow-up care necessary. Supervisory mechanisms should be put in place to ensure adherence to these.

* Besides engaging in education and awareness raising projects, NGOs could play a significant role in promoting quality of care, and bringing to public attention any instance of abuse or substandard care.

* An independent monitoring team which networks with various NGOs and local level organisations may be a way of ensuring adherence to standards in quality of service delivery, and prevention of abuses. The team may itself investigate reports of abuses or constitute a fact-finding group, as appropriate, and recommend appropriate redressal. In order that it is truly independent and credible, such a team should not be funded by donor agencies that are known to have a special interest in promoting population control.

* There is need to examine legal and constitutional provisions for redressal in case of violation of people's right to choose whether or not to adopt contraception, and what method to adopt; and make known/publicise widely about such redressal mechanisms.

* In the area of new contraceptive technologies, the group had the following recommendations to make:

- GOI should refrain from introduction of new invasive contraceptives in the name of widening 'choice'. It should instead, improve upon existing services which are among the major barriers to real 'choice', women hesitating to use these services because of their lack of trust in the system.
  (Some members of the group went a step further, to state that provider-controlled, long-acting, hormonal methods should not be introduced in the programme. There was, however, no consensus on this view).
- No new contraceptives in the country should be introduced without well-conducted clinical trials establishing their long-term safety.
- Introduction of high-cost new contraceptive technology, backed by donors' subsidy is not an appropriate policy especially at a time when there are severe constraints on public expenditure. It should be a cost effective exercise.
- Clinical trials of new contraceptive technologies should be methodologically sound and ethically beyond reproof. They should be conducted on volunteers who opt to participate in the trial of their own free will, after having been giving complete information on the trial. No one who is in a vulnerable position or whose health is known to be compromised may be inducted, for example patients from gynaecology wards of hospitals; poor women who are given money or other incentives.
- Results of clinical trials, past and present, should be made public, and available to any woman who seeks it.

NARRATIVE REPORT OF PLENARY PROCEEDINGS

Introduction: Reproductive Health Care

The meeting started with a brief introduction seeking to clarify the working definition of 'reproductive health' and to present the major objectives and agenda of the meeting.

The central objective of reproductive health programming is to enable women to

* regulate their own fertility effectively by conceiving when desired, terminating unwanted pregnancies, and by carrying wanted pregnancies to term
* remain free of disease, disability, or danger of death due to sexuality and reproduction
* bear and raise healthy children

To achieve the above objectives, a reproductive health care programme would have to be comprehensive, providing

- education on sexuality and hygiene
- education, screening and treatment for reproductive tract infections and gynaecological problems resulting from sexuality, age, multiple births and birth trauma
- counselling about sexuality, contraception, abortion, infertility, infection and disease
- infertility prevention and treatment
- choice among contraceptive methods, with systematic attention to contraceptive safety
- safe menstrual regulation and abortion for contraceptive failure or non-use
- prenatal care, supervised delivery and post-partum care (Germain and Ordway 1989)

To be effective, reproductive health programmes need to be sensitive to socioeconomic as well as gender dimensions of health problems. We need more than medical interventions to deal with them. Further, they have to be concerned with reproductive health problems arising throughout women's life cycle, from puberty through menopause and after. Reproductive health problems have to be understood within the context of women's general health and well-being, since they are interconnected. Clearly, women cannot have a good reproductive health status, unless they enjoy good overall health status as well.

Reproductive health is a vast subject area, but for the purpose of the present meeting, six main themes had been identified.

These were:

Maternal Health

Abortion

Reproductive Tract Infections

AIDS and HIV

Contraception

Following the introduction, each of these topics was introduced in the plenary by a team of two or three participants. Their presentation was based on their experiences, and focused on medico-social aspects of the issue as well as on a critique of existing policy. The participants then discussed the same topics in small working groups, to formulate policy and programme recommendations.

MATERNAL MORTALITY AND MORBIDITY

Maternal mortality is defined as the death of women during pregnancy, delivery or within 42 days post partum, from causes related to these, or from conditions aggravated owing to the pregnancy and delivery. The maternal mortality rate (MMR) in India is extremely high, and is estimated to be around 500 per 100,000 live births. Every year about 75000 to 1,00,000 women in the reproductive age group die due to causes related to pregnancy and child birth. About 75 percent of deaths are caused due to direct obstetric causes and 25 percent due to indirect obstetric causes such as anemia, hepatitis, violence, injuries etc. Maternal morbidity owing to complications of pregnancy, child birth and puerperium are stated to be 15 to 16 times higher than maternal deaths.

There is a tendency to view maternal health in isolation of other women's health problems, and to plan narrowly focused health interventions to deal only with problems in pregnancy and birth. The fact that poverty and gender based discrimination causes women's health status to be very poor from infancy and childhood through adult life, and that many of the problems related to pregnancy and childbirth are related to this, is often overlooked.

Even within such a narrow approach, there is much more that needs to be done in the area of maternal health care. Even today, the vast majority of deliveries take place without trained attendance, and there is no post partum care to speak of. The clubbing together of maternal health care and family planning programme, has been responsible for its neglect, given the preoccupation of both planners and service providers, with population control. Women, due to their low social status, and lack of awareness and self esteem, and lack of decision making power, are not able to utilise even the limited services available. In India, social and cultural factors play a major role in the high maternal mortality and morbidity.

The subject "Maternal Mortality and Morbidity" was introduced in the plenary by three resource persons. These provided a critique of Maternal Health policy and experiences related to maternal health with special emphasis on social and cultural aspects.

Dr. Dilip Mavlankar, Assistant Professor, Public System Group, Indian Institute of Management, Ahmedabad, presented an analysis of the policy and programmes for Maternal Mortality and Morbidity and concerns related to it.

In his review of the Maternal and Child Health (MCH) policy in India he briefly touched on a history of policies. The Bhore committee (1946) specially focused on Maternal health care. From 1970s onwards the programme was linked with the Family Planning programme. He highlighted the fact that health policy document of 1983 includes only one paragraph on MCH, and that too, in relation to high birth rate and high infant mortality rate. The policy recommended a comprehensive programme for ante natal, intra natal and post natal care and continuation of the TBA training. It emphasised the need for maternal health services to reach the door step, with home deliveries being conducted by trained birth attendants, and timely referral of complications. More recently, MCH has been integrated into Child Survival and Safe Motherhood Progamme (CSSM) consisting of 11 components out of which 6 cater to mothers. One of the neglected aspect is that of referral of complicated cases.

Critiquing the programme, he said that while it has set itself ambitious goals, it does not have the infrastructural facilities to achieve it. The existing supply and maintenance of the facilities and the services was found to be weak and erratic. There is a large proportion of vacancies for personnel positions, and low motivation and lack of accountability characterises staff performance. Staff training programmes are usually one time efforts without ensuring timely follow up and emphasis on the theoretical aspects.

In addition, political interference leads to further delay in administrative procedures which accompanies poor management practices resulting in ineffective implementation of the programme at the village level. The monitoring of the programme is target based giving less importance to the quality of the programme.

The following were listed as the reasons for the low coverage and high maternal mortality and morbidity:

* Lack of awareness in the community regarding the services available.
* The community fails to perceive the benefit of preventive services.
* Services are not available, accessible or acceptable

* Poor quality of the services

* Maternal health is not considered a priority by the service providers as they have to accomplish unrealistic targets of sterilization for birth control.

* Low value accorded to women's health in the society

* Politically, administratively and even among the women's groups maternal health is accorded low priority

* Programmes are insensitive to women's need for privacy and empathy, especially as related to delivery care.

Dr. Vinaya Pendse, Gynaecologist and Obstetrician from a Udaipur hospital, presented an analysis of 929 maternal deaths amongst 1,11,153 deliveries conducted in the Udaipur hospital over the period of 1971-1993. This makes for a maternal mortality rate of 835 per 100,000 live births, a very high rate by all standards of comparison. Though hospital statistics do not reflect general mortality of a community (as it is bound to be higher due to high referral rate of high risk pregnancy cases and complicated cases), it does help in planning strategies for improvement of maternal health programme.

While analysing the reasons of high maternal mortality (MMR) she mentioned that 70% of the Indian population lives in rural areas, where 85% deliveries are conducted at home, out of which only 33% are attended by trained personnel. In such a situation, childbirth complications are more likely to remain neglected and unattended. In rural areas where the MMR is high, the community also faces the additional problem of poor transport facilities, ignorance, illiteracy, lack of awareness and undernutrition.

Secondly the Government infrastructure in rural areas is usually under staffed and poorly equipped and the Government machinery at the rural panchayat level is not trained/competent to register MMR. Hence the problem remains underreported and invisible.

She highlighted that the problem of MMR is closely related to gender based discrimination in our society. In our social structure women are considered to be less important than men at all levels. Even in educated families, female children are considered an unwanted burden. Therefore to tackle the problem only from the medical angle does not suffice.

During her discussion, in addition to medical reasons she highlighted the different gender specific socio-economic and cultural factors that are responsible for the high maternal mortality and play a major role in causing maternal deaths, and the constraints that an obstetrician faces in the treatment of such cases.

About 60 - 65% maternal deaths in her hospital were avoidable, and could have been prevented. The majority of the cases were unregistered pregnancies (90%) and from rural areas (73%) and belonging to the poorer segment of the community.

About 38% women come to the hospital with the referral slip whereas 62% come directly which indicates the weak referral services at the rural level. Majority of women reach hospital very late and in a highly neglected condition (80%), about 32% of cases died within 4 hours of admission. Also they reached the hospital only when all efforts for a delivery at home had failed.

Women arrive at hospital (replete) with risk factors. They are often transported in filthy and unhygienic conditions, and arrive dirty. If the women need to be operated, initial preparation requires a lot of time leading to loss of precious time and making the case more complicated.

Taking patient history is a major step in case management, to aid in planning for reduction of MMR. Due to a number of reasons, this step becomes very difficult. The patient arrives at the hospital in a very serious condition, unconscious, semi conscious or is in agony. She is in no position to reply to the queries posed during history taking. Many a time, differences in language/dialect is also a barrier.

If the patient is accompanied by a male member of the family he is usually unaware about the history and the complication of the case. The TBA who has handled the case at the village level rarely accompanies the women and at times when she comes she remains "incognito". The medical staff is also prejudiced against the TBA, and considers her as someone who is responsible for the complication in the first place. Therefore her opinion is never asked. In such a situation, it is therefore very difficult to elicit accurate information like amount of loss of blood, extent of the force used to get the delivery done etc.

Many a times, incorrect history is given. In some cases at the hospital level if an inexperienced doctor is available incorrect case history misleads the doctor and the case gets further complicated. Often incomplete and incorrect information related to family size is provided, owing to the fear of being forced to accept sterilzation if they had more than two children.

Villagers who come for the first time to the hospital get frightened by the structure and the unsympathetic attitude of the hospital staff.

Many a times women come loaded with ornaments and in cases where the woman has a swelling on hands and legs it is very difficult to locate a vein for administration of an IV drip. At times the goldsmith has to be summoned to cut open the ornaments.

If the woman needs blood, the doctor faces other kinds of problems, as the family members are not usually willing to donate blood to women. A lot of time and energy is wasted in persuading the family members to donate blood.

Dr. Pendse had faced situations where the man had changed his identity from a husband to a neighbour just to avoid blood donation. At times when they are told that the woman will die if blood is not provided they are willing to let her die instead of donating blood. They are even ready to write frankly on a legal paper "Knowing fully well the consequences of maternal death of my wife I do not want to donate my blood. I take full responsibility". Often the women patient, if conscious, urges the doctor to let her die, but not to take blood donation from her husband or son.

Dr. Pendse also stressed that the family planning programme had drawn attention away from the important area of maternal health, which has resulted in lack of Government and public attention to the problem. Also the problem of the MMR has been grossly neglected by several womens' groups, perhaps because they want to dissociate from the image of women as mothers rather than persons.

She felt that doctors especially obstetricians also played a role in non-recognition or non-highlighting of the problem of Maternal Mortality because of their preoccupation with heavy load clinical work which is ever increasing in government hospitals. It is always discussed within the four walls of the hospital and how to prevent majority of the avoidable maternal deaths is never discussed in public.

Dr.D.K.Srinivasa, of the Jawaharlal Institute of Postgraduate Medical Education and Research, Pondicherry in his presentation tried to highlight the socio-economic, cultural and institutional reasons related to maternal morbidity. His presentation was based on a study undertaken by his department under his leadership.

He reported that in his study the combined direct and indirect obstetric morbidity rate was 741/1000 pregnancies and the obstetric morbidity rate taking a select group of most common conditions, was 251/1000 pregnancies.

The major constraint he faced in his study of maternal morbidity was related to gender biases in the society. He mentioned about low social status, lack of self-esteem and religious restrictions constraining women. Lack of awareness about various morbidities arising from complications of maternity , and perceived in appropriateness of seeking care for 'personal' and women-specific conditions such as these, were other important constraints highlighted by his study. To emphasise how social factors influence maternal morbidity he presented excerpts from a few dialogues with women. Presenting a flow chart depicting a 24 year old women's modes of travel to reach a health facility for treatment, he clearly illustrated the many dimensions and severity of the problem. Lack of a suitable mode of transport, dependence on other persons, especially men, in the absence of public transport, to take her by cycle; the need for a companion to accompany her to the health facility for moral support- these were only some of her numerous problems. When analysed thus, it becomes far more than merely a 'transportation' problem.

Dr Srinivasa observed that very few women reported complications related to anaemia among the morbidities reported. This could be due to the fact that women were not able to perceive anemia as a serious complaint, and put up with poor health as their lot as women. He felt that women should be provided with necessary information related to health, and that they needed to develop their self esteem and understand that they have the right to be healthy. Assertiveness and empowerment training for women need to be organised to bring about a positive self-

image in women and alter their health seeking behaviour. Decision makers in the family also need to be oriented.

An interesting fact reported was that maternal mortality was nil in the JIPMER rural and urban health centre areas in the last few years and, despite this, maternal morbidity continue to occur. Thus, elimination of maternal morbidity does not automatically follow elimination of maternal mortality. Special efforts focused at maternal morbidity are needed.

He further felt that quality of services need to be improved and made more affordable. Another major effort that is required is to enhance political will by educating the political leaders and administrators to recognise Maternal Health as a major public health concern.

REPRODUCTIVE TRACT INFECTIONS

Reproductive Tract Infections (RTIs) are a major health concern for Indian women. RTI includes Sexually Transmitted Diseases (STDs), diseases due to overgrowth of organisms normally present in the genital tract, and other iatrogenic factors such as deliveries by untrained persons, illegal abortions and when proper aseptic precautions are not observed during gynecological procedures.

RTIs are a frequent problem for poor women, yet they often go undiagnosed and untreated. When left untreated,RTIs lead to complications such as ectopic pregnancies, cervical cancer and infertility. All RTIs are preventable and most (except viral ones) are curable. Despite this, they have not been accorded the priority they deserve by policy makers and donors, and services are practically unavailable at the community and health centre levels.

The subject of Reproductive Tract Infections was introduced by Dr. Sridhar, Sewa Rural, Jhagadia, Gujarat. His narrative drew from his field experience in working for women's health.

Dr Sridhar's talk touched on the consequences of RTIs and outlined suggestions for interventions. RTIs underlie 10-50% fetal wastage including abortions, still births, prematurity and growth retardation of foetus and 30 - 50 % prenatal infections. Both these consequences ultimately contribute to the high infant perinatal mortality rates. RTIs can lead to cervical cancer, AIDs, HIV, infertility (up to 70%), ectopic pregnancy, pelvic pain, backache, and dyspareunia. The short term and long term outcomes of RTIs can thus lead to medical complications, social ostracism and emotional distress.

Presenting the perceptions of women on RTI, he said that many rural women believed that RTIs are caused due to diet, or promiscuity; starts at puberty; and is spread through men. The white discharge is believed to originate from bones and spine.

He strongly felt that it is necessary to consider socio-cultural dimensions of RTIs both for prevention as well as for the treatment.

He suggested timely treatment, primary prevention and operational research at the level of interventions. In rural areas he felt that the prevention and treatment can be integrated at the level of existing Primary Health Care (PHC).

A lively discussion followed Dr Sridhar's presentation. Some of the points made were as follows:

* The incidence of STDs has increased at a rapid rate during the last few decades because young people have become more sexually active.

* Poor economic status leading to migration often forces couple to prolonged separations, leading to unsafe sexual practices which would contribute to an increase in STDs.

* Increased sexual abuses, and sexual violence leads to increased incidence of sexually transmitted RTIs.

* To some extent, the problem of RTIs is further aggravated due to poor menstrual hygiene.

* Neglect of asepsis in gynaecological and obstetric procedures is another common route for RTIs. Given the poor quality of services in family planning, IUD insertion is most commonly associated with the incidence and/or aggravation of RTIs.

* Fear of exposure and embarrassment is a major deterrant to seeking STD treatment. In addition, treatment is

often very expensive. Being related to sexual behavior it is also very difficult to assess and suggest behavioural changes to prevent recurrance of the disease/infection.

* RTIs get low priority in policies and programmes because they are not considered fatal. It was also felt that RTIs are often thought to lead to stigmatization of Family planning programme and are therefore given low priority.

* Women are found to be more vulnerable to RTIs because they are extremely powerless in the Indian social and cultural context and lack negotiating skills in their sexual lives both within and outside marriage. Thus, they have no control over their partner's unsafe sexual behaviour, and no power to refuse sexual relations with him.

* The present social structure does not provide women with an enabling environment and privacy to facilitate positive health seeking behaviour for RTIs, especially those sexually transmitted. This leads to delayed identification, misery, pain and further complications.

* Women also suffer more serious social consequences arising from untreated RTIs. The problem of infertility often leads to marital violence and abandonment of women. RTIs observed among prostitutes is another neglected area and they are always blamed for the spread of the disease.

* RTIs as a problem do not get priority in the existing health programmes due to lack of gender sensitivity among health planners and policy makers, medical professionals and para medical staff.

HIV/AIDS

It is now widely recognized that HIV/AIDS has assumed the status and dimensions of an epidemic in many parts of World. WHO has estimated that by the end of 1991, about 1 to 4 lakhs persons in India were likely to be HIV positive. 310 AIDS cases have been reported in India up to March 1993. Of all persons suffering from AIDS, one third are women. Biologically, women are ten to thirty times more prone to AIDS infection at any given contact due to a larger exposed surface of virus penetrable membrane.

The subject of HIV/AIDS was introduced to the participants by Ms.Geetha Sethi, Consultant, National AIDS Control Organisation (NACO) and Ms. Parbeen Singh, Free Lance Consultant.

Ms. Geetha Sethi in her presentation outlined the present status of HIV infections/AIDS in India. She mentioned that the AIDs programme has been integrated with the existing health care programmes (in response to which several participants raised doubts about its validity in practice).

The NACO has in addition, taken various steps for the prevention and control of HIV infection. Guidelines have already been issued by the Ministry of Health regarding blood transfusion, and rational use of blood. STD services were being strengthened, as these are high risk groups for HIV infection.

Women, particularly those who are illiterate and from rural areas have poor access to information and more vulnerable to HIV infection, for much the same reasons as in the case of RTIs. They are also in danger of infection through blood transfusion for obstetric emergencies. At present, the only way in which a woman can protect herself from infection is through negotiating condom use by her sexual partner, a difficult proposition considering how little say they have over their partner's sexual behaviour. The female condom may be a better alternative but it has not yet been introduced in the country.

For prevention of AIDS, sex education is an effective strategy and can be imparted both to adolescent boys and girls at school and integrated in the college curriculum. Special educational programmes can also be organised at tourist sites, railway stations and for armed forces. This can be done through the collaborative efforts of NGOs and GOs.

Ms. Parbeen Singh in her presentation emphasized on the gender dimensions of HIV/AIDS infection, focusing on the following points :

Biologically, women are more prone to AIDS infection and combination of gender based discrimination and a low socio-economic status again makes women more vulnerable to infection than men. She felt that these two points are not given due attention in policy formulations and implementation of programmes. Unlike men, who when provided with information and means are able to protect themselves from sexual and drug misuse and infection, women are not socially and culturally empowered to do so. Even if they have the knowledge about safe

sex practices and drug use, their lack of autonomy does not allow them to take decisions that concern their own lives and bodies.

Men's mobility and the fact that they often have to spend several days away from home, makes them seek sexual fulfilment elsewhere which exposes them to a high risk of infection which in turn is passed to their wives or other women with whom they have sexual contact.

It is an established fact, that most infected women become infected during sexual intercourse with their husbands and regular male partners. Therefore the responsibility for prevention needs to be shared by men and women rather than shouldered by women alone. For example, instead of asking women to 'negotiate' for condom use with their partners, there needs to be greater emphasis on the use of condoms by men on their own accord.

Men must learn to respect and accept women as being equal partners in all activities that concern both of them. Mutual respect and trust, open and honest communication about sexuality and sexual behaviour can prevent the transmission of sexually transmitted diseases and AIDS. She suggested that women need to be organised so that they work together to be empowered to demand their rights. Women's organisations and committed people working in the area of social and economic upliftment as well as human rights can extend valuable support to organise women in the fight against AIDS.

ABORTION

Abortion related morbidity and mortality is a serious concern in India. It is estimated that about 65 lakhs abortions take place every year in the country, out of which 25 lakhs are estimated to be spontaneous (natural) and the rest (about 40 lakhs) induced. A large proportion of induced abortions are illegal, induced by unqualified persons and/or women themselves. Such illegal abortions are associated with extremely high risks which may result in serious complications or deaths. About 12% of maternal mortality is due to abortion alone.

That illegal abortions take a high toll of lives in our country despite having provisions for legally terminating a pregnancy calls for a need to examine the underlying causes in detail and rectify these.

The topics were introduced to the participants by Ms. Sudha Tewari, Managing Director of Parivar Seva Santha and Ms. Rami Chhabra, Free-lance Consultant. The topic could not be discussed at length in the small group due to lack of time. The details of plenary discussion are given.

Ms. Sudha Tiwari presented the overview of the problem of abortion. She highlighted that while an estimated 11.2 million abortions take place in the country every year, only 6.7 million have been officially reported. There seems to be a high rate of unreported abortions. The present abortion rate is 452 per 1000 live births. She briefly mentioned about the MTP act, availability of the MTP services, and training of the medical personnel.

Based on data from Parivar Seva Sanstha's clinics, she discussed the knowledge and attitude of the clients, providers and policy makers. Knowledge about induced abortions was 85.8%, while awareness about provision of legal abortion was 36.5%. Knowledge of availability of MTP services at PHC was 46.5% She mentioned that even though there is social stigma attached to induced abortions, 2 out of every 10 women would have at least one abortion in their entire life span.

While discussing the experience of Parivar Seva Sanstha (PSS) she informed that PSS had performed 51433 abortions in 1993 which contributed to 8.6% of total reported MTPs in India. The PSS has, through its contribution to providing high quality abortion services, been able to highlight the unmet need for MTPs, and have had a catalytic effect on quality, availability and cost of MTP services, and had to some extent reduced the incidence of backstreet abortions. The PSS have been able to set standards of quality services, counselling, medical skill and client care. While elaborating on the counselling she highlighted that they perform it before and after abortion, and also motivate abortion seekers for family planning acceptance. The positive experience of PSS could serve to inform improvements and changes in the government's health services, and MTP centres in the public health services could be encouraged to adhere to the same set of standards in service delivery, provision of information and counselling.

Ms.Rami Chhabra's presentation drew on a review of abortion studies and data, recently completed by her.

Data indicates that official figures for MTP have increased from 0.278 million in 1976 - 77 to 0.632 million in 1991 - 1992, an increase of 8.49 percent per year. The number of approved centres for MTP have also increased from 2149 in 1976 - 77 to 7121 in the corresponding period showing an increase of about 15.42 per cent per annum. Comparing the two trends, it is evident that the performance of MTP has not kept pace with the expanding network of MTP centres. It seems likely that at least twice as many MTPs are being conducted by qualified physicians in recognised facilities, as are reported. Cumbersome reporting procedures are a major deterrent.

MTP facilities are still grossly inadequate as compared to the estimated need. Most MTP facilities are urban, and only 1800 out of over 20,000 PHCs provide MTP services. While women prefer qualified physicians and approved institutions, poor knowledge of such facilities, poor accessibility, as well as general dissatisfaction with public facilities owing to lack of privacy, courtesy, and lack of compassionate interaction by service providers, drives them to the private sector. The private sector consists of qualified and registered services, facilities with qualified personnel but unlicensed, and unqualified personnel. It is the last category that dominates service provision, contributing to serious complications and high mortality.

As for issues related to licensing of health facilities for performance of medical termination of pregnancy, the MTP (Amendment) Rules 1977 which are presently applicable specify that the experience or training required for medical practitioner to qualify for registration to undertake MTP procedures is less than 3 years of practice as obstetrician/gynaecologist, or at least one year of hospital-based experience or performance of at least 25 MTPs. If undertaken by anyone without the requisite qualifications, the procedure is considered criminal. However, there is a serious shortage of trained personnel to perform MTPs. It may be worthwhile re-examining these licensing requirements, and training paramedical personnel to perform menstrual regulation in the early stages of pregnancy, to improve access to timely pregnancy terminations.

In conclusion, she stated that the MTP programme was in a dismal state, and needed critical attention for streamlining of service delivery; and more critically still, must acquire a vision beyond a 'supplies and techniques' scheme.

In the brief plenary discussion which followed, some important points were raised:

* The MTP Act, although liberal to the extent that it provides scope for legal abortions, still vests the power to make decisions regarding whether or not to provide abortions, with the medical profession. This should change, and abortion should be made available on demand to women.

* Inflexibilities in the Family Welfare Programme, such as not offering temporary methods to women with two or more children, lead to unwanted pregnancies and abortions in women who are not yet ready to accept permanent methods of birth control.

* The practice of insisting that women with two or more children should accept sterilisation when seeking MTP, causes many women to turn to illegal abortions.

* Women's lack of awareness and access to MTP facilities is a consequence of women's powerlessness in a patriarchal social structure.

* Selective abortion of female foetuses was a tricky issue in the context of acknowledging women's right to abortion. The only approach to dealing with it effectively was long-term, and centred around improving women's status and empowering them, to deter devaluation of daughters.

CONTRACEPTION

The Government of India recognized the need for population control and was the first in the world to launch a family planning programme in the year 1952. It has adopted various strategies over the past four decades principally to bring about fertility decline, and has been driven by demographic goals. Far from meeting women's need for fertility control, it treats women as the perpetrators of the 'population problem' , and exhorts them to stop reproducing through a combination of carrot-and-stick policies. In order to further accelerate the rate of fertility decline, the programme is now planning to introduce several new high-tech contraceptives, for some of which clinical trials are now under way. Numerous controversies surround the subject of family planning and contraception, and it is a major women's health concern especially in the context of being delivered through a population-control programme.

The subject was introduced to the participants by Dr. Pramila David Director, Centre of Population Concerns and Dr. Mira Shiva. HOD, Public Policy, Voluntary Health Association of India.

Dr.Pramila David presented a critique of the programme. According to her, any analysis of policy has to go beyond its pronouncement and look into to what it achieves the operational level.

Some of the assumptions that have influenced family planning goals and the direction of the programme have been, that:

* Goals driven by demographic concerns could influence human behaviour, that too in an area as complex and personal as contraception.

* Young men and women in this country irrespective of their socio cultural and economic status or rural/urban divide would control their fertility if provided with technically feasible and modern contraceptives.

* Centrally planned targets will be achieved as directed, irrespective of the contraceptive needs of a given community.

* Service providers, medical officers and paramedical staff at the field level administrators would be able to provide the much needed services after brief training on the technological aspects.

* Money incentives to the acceptors would bring both, enable greater acceptance and help the programme in achieving its targets. A combination of threats and incentives to service providers would bring about desired results.

* In events when achievements fall short of set targets " Camp approach" could be instituted with a view to achieve the targets; and/or incentives further enhanced.

* When a particular method of contraception fails, replacing it with newer methods would solve the problem, irrespective of the reasons why the earlier method failed.

* Younger couples can be made to accept spacing methods because of its demographic impact.

These assumptions indicate how the policies have been formulated, and goals were established. It also explains the responses of the people to the programme at the implementation level. It also indicates the kind of managerial, marketing and administrative sense had gone into the design and redesign of the programme in the past.

She emphasised the importance of learning from past mistakes. To convert a complex human phenomenon ie. population growth and its potential into a game of numbers has been one of the programmes biggest mistakes. Women cannot be called upon to fulfil a national need, unless it happens to be their own need as well, especially in a democratic set up such as ours. Today, women would like their partners to take equal responsibility in birth control. Concerted efforts at the programme level are required to increase male responsibility for birth control.

Other limitations quoted by her were that the contraceptive services provided till the date have demonstrated a total lack of care and concern for the larger well being of the client. Such being the experience of a large proportion of acceptors, many other potential users hesitate to accept any form of contraception, and may resort to MTP.

Any welfare service, if provided out of context to its natural environment, in other words, contraceptive services provided without reference to its origin i.e. sexual or reproductive health care will erode the professional

ethics and dignity of the service providers thereby lowering the morale and motivation of all those who are providing services. They are made to function in an environment which is distasteful to them. Currently a two way negative cycle has been created wherein both the programme personnel and potential client are rejecting the programme.

She emphasized that in order to succeed, the family planning programme needs to be reviewed and redesigned so that the policies, programmes, administrative procedures and evaluation criteria are more people centred. In a nut shell, a change in the thinking of the policy planners and programmers is to be ensured.

She recommended the following :

* Create conditions and environment to prepare the client groups through education, social action, and a broad range of health care services so that the client would seek reproductive health care for her/his own benefits.

* Provide a range of contraceptive choices and assistance to clients to choose with care the contraceptive that is best suited to them. In fact, this can be enabled by trained medico social workers.

* Individual check lists to be prepared and made available to all those who request contraception and to be enlightened regarding the screening procedures, suitability, effectiveness, side effects and complications of each contraceptive.

* Provide quality services with care and competence. Follow up regularly with aftercare services to keep the contraception acceptor satisfied. Take full moral responsibility for the after effect of services.

* Targets to be prepared by the field personnel with client participation. Total range of reproductive health care services in each village to be planned and a plan of action for each type of service to be prepared.

* Abolish centrally planned targets, incentives and camp approaches.

* Change evaluation indicators to include women's gynaecological concerns and quality of services.

*Allocate adequate resources for physical amenities, and trained human resources.

* External monitoring and evaluation of government programmes to be introduced.

Dr. Mira Shiva approached contraception from the point of view of Primary Health Care Provider, Rational Drug Use, as well as Women's Health advocate.

Policies related to contraception have continued to be centre stage for several decades now, specifically in third world countries, with only terminologies changing, from maternal and child health care to safe motherhood to reproductive health. Contraception has received priority in planning, budget allocation, research and even provision of services. In spite of this, contraceptive needs of women are not adequately met and policy planners feel dissatisfied as the desired performance in demograhic terms has not been achieved.

This preoccupation with implementing population control policies has caused deep concern among health personnel who subscribe to the concept of primary health care, holistic health and rational drug use. Such a preoccupation is unfortunate, because it has resulted in the neglect of other health services. It was not women's contraceptive and health needs that guided the policies but demographical goals for reducing population growth rates and fertility rates. Had the finances used for incentives and organizing camps been used to strengthen primary health care centres, which would provide contraceptive services as part of general health services and not in place of it, women would have had access to reproductive health care. Population control has caused planners and service providers to turn a blind eye and a deaf ear to the genuine needs of women.

Even in the case of medical education and training of health workers, while subjects such as population explosion, and different contraceptive methods is introduced, never discussed are issues related to women's powerlessness in decision making about their own reproductive lives, the worsening of the inverse sex ratio, women's solitary shouldering of the responsibilities of conception, contraception and child care.

In demographically driven population control programmes, women are treated merely as numbers. If due importance were given to issues beyond contraceptive technology: e.g. female literacy, women's social, economic and political status, property rights, employment and basic minimum wages, meeting basic needs for food, shelter,

education and health care to ensure child survival, it could have made a tremendous contribution to voluntary reduction of family size.

It is clearly known that it is the fulfilment of several basic needs and improvements in child survival that has led to decrease in birth rate in many countries. Focusing on contraception when the former is getting eroded will not help.

Over-population is considered as a cause of poverty and environmental degradation. By so defining the causes of poverty, attention is shifted from the real problem: increasing unequal distribution of resources and opportunity, power and control. The situation has become worse with the new economic order. In India in those states where a large number of poor live, where social status of women is low, there has been a worsening of adverse sex ratio, female foeticide and dowry deaths. Where female literacy is low, women have poor access to education, health care and income generation, birth rates and maternal mortality are higher.

We find an unnatural concern for women's unmet needs on the part of policy makers. However, these are not defined in the context of women's unmet health needs but only in context of "unmet contraceptive needs". No one is talking about unmet needs in the area of food, clothing and shelter and basic amenities. This concern for unmet needs is ironic especially at the present juncture when the conditionalities imposed by international financial institutions have cut funding to the social sectors. One important area negatively affected is the public distribution system (PDS), which has resulted in increase of food prices. In the present social set-up, women's health would be most adversely affected. One can well imagine the consequences, when over 70% of pregnant women are anaemic as it is.

Another grossly misused term is 'widening choice'. These 'choices' for women are being considered merely in context of contraceptive technology but little consideration is given to choices which would provide options for improvement in work, income, education, and access to better living conditions; options to come out of oppressive, degrading, violent, marriages, and so on.

In spite of use of the terms Family Planning, Family Welfare and Population policies, the focus has always been on increasing the use of contraceptive methods and development of invasive, long acting, provider controlled, expensive contraceptive technologies. Each new contraceptive technology, when first introduced was greeted as the ultimate in successfully dealing with the "population bomb". The reality is that the targeted population for the programme was mostly poor women, who are considered as ignorant and irresponsible, and not able to control their fertility. Their participation in the family planning programme meant unquestioning acceptance of the recommended method.

The attitude of family planning programme/peripheral health worker is target oriented. If serious attempts would have been made to upgrade health services so as to ensure basic health needs specially for women's health problems, the need for newer invasive hormonal contraceptives targeted at women ,would have been much lower.

However, when faced with difficulties in acceptance of family planning by women, the programme sought to find an easy way out through introduction of newer technologies which would demand even better health infrastructural facilities. What is needed is addressing the basic problems with respect to provision of contraceptive services, especially those related to screening for contraindications and managing/treating problems thus detected, For example, there is absence of adequate diagnostic and therapeutic facilities to diagnose and manage gynaecological infection prior to inserting IUDs. Inserting an IUD in a women suffering from gynaecological infection without adequate treatment is not only unethical but also "bad medical practice".

Contraception means being able to prevent conception, either naturally, through periodic abstinence, or through the choice of contraceptives which may be short acting or long acting. Abstinence which has been part of Indian cultural ethos, whereby on certain days, and for a certain period after delivery etc. couples were expected not to cohabit. During Brahmacharya- the period of youth before marriage- it was expected that sexual urges and sexual energies would be controlled.

Opting for a technological solution to the issue of fertility control, in a mechanistic way, is far from empowering. Fertility awareness- the knowledge that a woman is fertile only during a specific period during her menstrual cycle, and about how to identify this period - and periodic abstinence during the fertile period, requires

the participation of both partners, and can be a good option for many. However, a study by the Planning Commission showed that only 2% of couples knew about the fertile period. Such natural methods have been systematically marginalised and invalidated in the technology-driven approach to fertility control adopted by the Indian family Planning Programme.

The Indian programme treats fertility control as the sole responsibility of women, and targets its messages and services almost exclusively at them. There is clear evidence of decreasing male responsibility in these matters and increasing sexual exploitation of women. An example of this is that while newer contraceptives are researched on women, an increasing variety of potency drugs for men are flooding the market.

If some proportion of the money and time spent on trying to get women to accept sterilization, could have gone in convincing the men for accepting vasectomy by removing fear of impotence, the men would have understood their role in family planning and need for male responsibility.

Acceptance of the fact that men have greater uncontrolled sexual urges which must be met either by wife, mistress or commercial sex workers, means the acceptance of a male dominated view to sexuality. Large number of women are impregnated against their will, inflicted with STDs & HIV/AIDS against their will from their partners whom they care for and trust. The issue is not merely of "Safe Sex" but of taking responsibility. The condom is used by the male partner for his own safety to prevent him from getting infected from a commercial sex worker. He does not feel the need for use of condom to protect his wife even if he has had multiple partners. Even when it is known that a large number of men have extra marital exposure, contraceptives are basically pushed on women.

Contraceptive methods most used during the past decades have been female sterilization and the IUD. Many women once assured that their babies will survive, decide to complete their families earlier with terminal method, not only because there is no worry of pregnancy afterwards, but also because of the luring money incentive provided.

The camp approach where numerous sterilizations especially female sterilization (with laparoscopy) are done is not only associated with unhygienic conditions, lack of aseptic conditions/procedures but has also resulted in systematic erosion of the PHC facility, facilities and undermined follow up and accountability.

Laparoscopic tubectomy could be a very good procedure if proper examination is done and the operation is not performed in a hurry. However, targets and their fulfilment at the end of financial year February-March have been associated with numerous complications and problems. The denial of the existence of these facts and attempts to cover up have led to perpetuating greater carelessness and less accountability. It goes without saying that voluntarily sought sterilization, done with proper preparation, aseptically with adequate follow-up is a genuine need of many women who have completed their families.

Newer hormonal contraceptives like Norplant, Net En, Depo-provera are long acting, invasive and provider controlled. They are all associated with side effects such as cancer, the disturbance of menstruation, amenorrhea, frequent bleeding and spotting. In several societies menstrual bleeding can create problems as it interfaces with praying, fasting, sexual intercourse and women's feeling of health and well being. Other side effects reported are headache, weight gain, dizziness, abdominal discomfort, mood changes, loss of libido and osteoporosis. Apart from this there is always possible to abuse the injectable, giving it to women without their knowledge that it is a contraceptive. Further, clinical trials for some of these contraceptives were being conducted unethically, recruiting lactating and other non-eligible women, often without adequate informed consent. The results of these trails were rarely made available to the public, especially in cases where trials are suddenly discontinued due to questions about method safety.

It is because of such concerns about the new hormonal contraceptives that several women's organisations had gone to court in India against the clinical trials for NET-EN, and were opposing the introduction of Depo-Provera and NORPLANT.

In conclusion she highlighted :

* Rational contraceptive care is an integral part of women's health care and primary health care. Improvement of the latter is to be given the highest priority to ensure quality.

* Ensuring basic health services for survival and development of children, and basic educational facilities for

primary education is a precondition for effective fertility control, so that mothers are not forced to have more children.

* Efforts at empowering women and ensuring socio-economic, political, demographic, legal and human rights, which provides opportunities for genuine development would greatly enhance women's control over decisions related to reproduction. Instead of being viewed as mothers and baby-makers, women's choice to remain single must become socially acceptable, and they should be able to opt out of marriage with sense of security and dignity. Acceptance of adoption of babies by single parents must be made. Social expectations from daughters need to be changed, and it should be acknowledged that daughters as much as sons, can be an asset and can take care of parents in their old age; they are not merely 'dowry needers'.

* External population control pressures, which distort contraceptive uses by forcing 'targets' and incentives must stop, especially as a part of conditionality for loans.

* Targeting women in Family planning programmes must stop and a genuine effort made at encouraging male responsibility.

* Fulfilling women's basic socio-economic needs would need to be a pre-requisite, or at least accompany efforts to meet women's contraceptive needs.

* Unbiased information related to contraindications and potential side effects of all contraceptives needs to be made available.

* Monitoring of service delivery, especially the assurance of free and informed choice, and the absence of any form of overt or covert coercion must be done by independent bodies, which should also look into complaints and deals with issues of accountability of service providers and compensation for clients.

* The equation by policy makers, of 'Contraception' with use of costly contraceptive technology needs to be questioned and challenged. Efforts should be made at creating awareness about safe periods.

* Potentially hazardous technology e.g. injectable and implants should not be introduced into the country or in the family planning programme, especially in the absence of adequate health care services.

CLOSURE OF THE MEETING

The meeting ended with the agreement that current policies and programmes related to reproductive health is inadequate, and insensitive to women's health needs, not to speak of the larger issues of status and powerlessness that adversely affect their health seeking behaviour. Drastic changes are needed, keeping in view a women's health and gender perspective. Mere use of the term 'reproductive health care' without changing its content to be holistic and comprehensive, and without strengthening primary health care in the first place, will once again lead to pushing population control in yet another way.

Participants gave very useful suggestions with regard to formulation of strategy, implementation, evaluation and monitoring of the programme. We hope that deliberations in this meeting and recommendations emerging from it would be used as a tool for lobbying policy-making and programme planning efforts.

(At the end of the meeting representatives of women's groups present expressed their concern that discussion generated during the meeting be appropriately used. They strongly felt that the draft report be circulated to participants before it gets finalized, and agreed upon).

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